STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVENUE ELKHART, IN46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/20/11 Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Elkhart was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The original building (North, East and South wings) was constructed in 1968 with an addition (Primrose and Southwest wings) built in 1975. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 175 and had a census of 152 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			

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	Based on observation and interview, the facility failed to ensure exit egress for 1 of 27 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. LSC Section 7.1.6.4 requires walking surfaces to be slip resistant under foreseeable conditions. This deficient practice could affect any residents, staff and visitors using the main entrance exit. Findings include: Based on observation with the maintenance supervisor on 09/20/11 at 1:00 p.m., the concrete	K0038	**K-38** **1. The concrete sidewalk has been replaced at the main entrance of the facility and there were no residents affected by this alleged deficient practice.** **2. Residents, staff and visitors residing at the facility have the potential to be affected by the alleged deficient practice** **3. Environmental/Life Safety Rounds which will include exit egresses will be completed on a monthly basis to ensure any changes in exterior surfaces are corrected or repaired as needed.** **4. Environmental/Life Safety inspection reports will be forwarded to the QA&A committee for review The results of these audits will be reported by the Director of Maintenance every 6 months and then the QAA team will determine the need for additional auditing until a threshold of 100% is achieved**	10/20/2011

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	surface outside the main entrance exit had seven cracks ranging three inches in width to 1/2 inch in width with a depth of 3/4 inch in some cracks. The maintenance supervisor stated he has been wanting to correct the problem for the last three years. 3.1-19(b)			
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 2 of 2 sprinklers in the inservice training room which were painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems. NFPA 25,	K0062	**1. The two automatic sprinkler heads were replaced by the Maintenance Director. There were no residents affected by the alleged deficient practice.** **2. Residents' residing at the facility have to potential to be affected by the alleged deficient practice.** **3. The Maintenance Director will perform environmental/life safety rounds which will include sprinkler heads on a monthly basis.** **4. Environmental/Life Safety inspection reports will be**	10/20/2011

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	1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could effect the staff in and near the inservice training room. Findings include: Based on observation during a tour with the maintenance supervisor on 09/20/11 at 3:20 p.m., the two automatic sprinklers in the inservice training room were painted. The maintenance supervisor stated at the time of the observation, he was not aware of the problem. 3.1-19(b)		**forwarded to the QA&A committee for review. The results of these audits will be reported by the Director of Maintenance monthly for 6 months and then the QAA team will determine the need for additional auditing until a threshold of 100% is achieved.**	

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K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 3 of 4 oxygen supply storage rooms were separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)2 requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects the facility's corridors where resident rooms are located including staff and visitors. Findings include: Based on observations during a tour	K0076	**1. The Oxygen Room Doors have been replaced and have the appropriate fire rating.** **2. Residents' residing at the facility have the potential to be affected by the alleged deficient practice.** **3.Enviornmental/Life Safety rounds which will include Oxygen storage rooms will be performed by the Director of Maintenance on a monthly basis and changes in door structure will be repaired as needed.** **4. Environmental/Life Safety inspection reports will be forwarded the QA&A committee monthly for 6 months and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved.**	10/20/2011

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	of the facility with the maintenance supervisor on 09/20/11 between 2:10 p.m. and 3:50 p.m., the doors to the oxygen storage rooms for the South, Southwest and East wings, separating the area from the adjacent exit corridor, did not have the required 45 minute fire rating and tag as evidence of the doors' fire rating. Each oxygen storage room contained liquid oxygen containers and various smaller oxygen gas canisters. The maintenance supervisor stated at the time of the observations, he was certain the oxygen storage room doors were rated at 90 minutes, but had no documentation to verify the rating. 3.1-19(b)			